Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

AUTHORIZATION to RELEASE INFORMATION

Name .....

Claim Number .....

Soc. Security No. (for ID only) .....

Date of Birth .....

TO: .....

You are authorized to give Labor and Industries, or its representatives, any information you may have regarding my condition while under your treatment. In addition to your observations, please include: records of medical history, examinations, consultations, x-ray reports, laboratory studies, operative and pathology reports, physician's and nurse's notes, hospital records, diagnoses, prescriptions or treatment information relating to any disease, injury or other physical condition. This original or a photostatic copy is acceptable.

Please release all records of treatment for: .....

.....

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.....

Data to be released includes: ☐ Psychiatric Care ☐ Alcohol Abuse ☐ Drug Abuse ☐ HIV/AIDS

and/or other information protected by Federal law.

.....
(Signature)

I understand I am releasing these records so that Labor and Industries can administer and process my claim. I understand these records will be treated confidentially in accordance with the laws of the State of Washington (RCW 51.28.070).

This authorization can be withdrawn by me at any time.

.....
Today's Date Signature

***Please send the information to:**

CLAIMS SECTION
DEPARTMENT OF LABOR & INDUSTRIES
PO BOX 44291
OLYMPIA WA 98504-4291

*Note: For your convenience, address will show through a standard window envelope.